

EXHIBIT 1

DATE 1-10-07

HB 2

# **Final Report and Recommendations**

## **Medicaid Commission**

**Presented to Secretary Michael O. Leavitt  
December 29, 2006**

**The Honorable Don Sundquist, Chair  
The Honorable Angus King, Vice-Chair**

## Letter of Transmittal

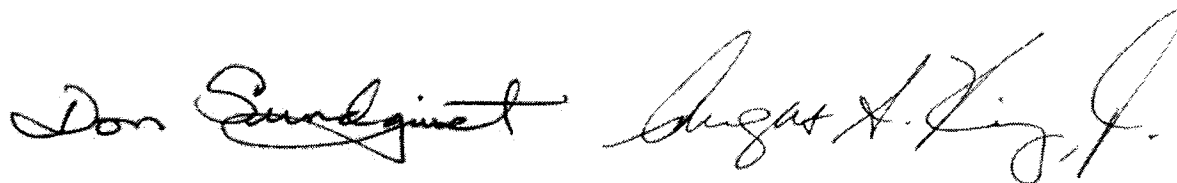
December 29, 2006

To the Honorable Secretary Michael O. Leavitt:

On behalf of the Medicaid Commission, we are pleased to transmit to you the Commission's second and final report reflecting our recommendations for the future long-term sustainability of the Medicaid program. The delivery of this report, along with our report dated September 1, 2005, fulfills the Commission's mandate as reflected in the charter.

We would like to thank our fellow Commissioners for their dedication to this effort and commitment to improving the Medicaid program.

Sincerely,

The block contains two handwritten signatures. On the left is the signature of Don Sundquist, which is written in a cursive style. On the right is the signature of Angus S. King, Jr., also in cursive.

The Honorable Don Sundquist  
Former Governor of Tennessee  
Founding Partner, Sundquist Anthony LLC

The Honorable Angus S. King, Jr.  
Former Governor of Maine  
Partner, Bernstein, Shur, Sawyer, & Nelson

## Table of Contents

Roster of Commissioners.....	iii
Acknowledgements.....	v
Executive Summary.....	vi
Introduction.....	1
Purpose of the Commission .....	1
The Work of the Commission.....	1
Background.....	2
The Medicaid Program .....	2
The Deficit Reduction Act.....	4
Foundation for Recommendations.....	5
The Context for Medicaid Reform.....	5
Recommendations.....	11
A. Long-Term Care.....	12
B. Benefit Design.....	13
C. Eligibility.....	16
D. Health Information Technology.....	17
E. Quality and Care Coordination.....	18
Conclusion .....	23
Appendix A: Vote Summary: Final Recommendations.....	25
Appendix B: Dissenting Reports .....	26
Appendix C: Medicaid Commission Charter.....	30
Appendix D: Roster of Meetings.....	34
Appendix E: Presenters.....	35
Appendix F: List of Testifiers During Public Comment Sessions.....	38
Appendix G: Commission Guidelines .....	42
Appendix H: Criteria for Final Recommendations.....	43

*Commission Staff*

Stacie Maass, Executive Director  
Margaret Reiser  
Emily Rosenoff  
Carrie Shelton  
Catherine Stevens  
Wendy Taparanskas, Ph.D.

**Acknowledgements**

The Commission is grateful to the many experts whose presentations and publications provided guidance in shaping the recommendations contained in this report. We appreciate all those who gave generously of their time to attend our meetings and present suggestions for improving the effectiveness and sustainability of the Medicaid program.

We would like to acknowledge the efforts and contributions of the staff whose energy and diligence were instrumental in enabling the Commission to complete its tasks. We also thank Charles Milligan and Ann Volpel from the Center for Health Program Development and Management, University of Maryland, Baltimore County (UMBC) for assisting with the preparation of this final report.

We also acknowledge Michael J. O'Grady, Ph.D., former Assistant Secretary for Planning and Evaluation, and Donald A. Young, M.D., former Acting Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, who both served on the Commission during their tenures at the Department.

## Executive Summary

Fundamental reform is needed in order to ensure the long-term fiscal sustainability of the Medicaid program. More than simply sustaining the program, the Commission believes that Medicaid can and must continue to provide quality care to promote the best possible health for all beneficiaries. Taken as a whole, the recommendations set forth in this report promote Medicaid's long-term fiscal sustainability, while also emphasizing quality of care. Key principles that must be part of this transformation include recognizing the long-term value of investments in quality, supporting state flexibility, and changing how beneficiaries partner with the Medicaid program by encouraging personal responsibility for health care decisions and promoting and rewarding healthy behaviors.

The Commission also believes that the health of beneficiaries will be improved through a more efficient Medicaid system that emphasizes prevention, provides long-term care services in the least restrictive appropriate environment, adopts interoperable forms of health information technology, coordinates care across providers and health care settings, and focuses on ensuring quality health care outcomes. Finally, although the Commission recommends several incremental measures to encourage individual planning for long-term care, the Commission also calls upon federal agencies and Congress to develop a fiscally sustainable plan for our nation's future long-term care needs.

The following recommendations reflect the Commission's strong support for state flexibility in the design and administration of the program. The unique characteristics of states suggest that a "one size fits all" approach to Medicaid is not appropriate. States have demonstrated success with innovative approaches to addressing the health care challenges they face, and we believe that beneficiaries will be best served if states are given additional flexibility to innovate. In addition, barriers to replication in other states should be reduced for programs that have demonstrated success. The Commission's support for state flexibility is consistent with its recognition that Medicaid must remain a financial and administrative partnership between states and the federal government. In the Commission's view, the federal government should continue to have a vital role in ensuring that the Medicaid program delivers access to quality health care for the program's beneficiaries.

### **A. Long-Term Care**

The anticipated costs for long-term care services in this country threaten the future sustainability of the Medicaid program. Medicaid is currently the largest single source of funding for long-term care services nationally, covering nearly half of all long-term care expenditures.

**1. Public policy should promote individual responsibility and planning for long-term care needs.** Congress, the Administration, and states should implement measures that encourage individual planning for long-term care, such as:

- Provide federal and state tax incentives to encourage individuals to purchase long-term care insurance. For example, there should be an allowance for early withdrawal of IRAs, or other federally-approved retirement accounts, for the purchase of long-term care insurance. Additionally, health savings accounts should be expanded for use for a wider

array of long-term care expenditures. Lastly, participating in the Long-Term Care Partnership Program is an option for states to provide such incentives.

- Provide new federal and state tax incentives to employers to offer long-term care insurance as an employee benefit.
- Provide tax deductions/tax credits to encourage those providing informal care (such as family members and friends) to continue in this effort.
- Promote the use of home equity by individuals to finance long-term care services needed to maintain the individual in his or her own residence and prevent or postpone Medicaid enrollment. Federal and state initiatives to support the development of home equity programs, such as reverse mortgages, should increase consumer awareness and access, ensure consumer protections, and encourage industry innovation.
- Increase state participation in the federally-sponsored Long-Term Care Awareness Campaign to improve public education about the importance of individual planning for long-term care needs.
- The Commission recommends a study of policy options for using alternative insurance models for the provision of long-term care services. This study should include analyses of costs, revenue and governmental administration.

**2. Changes in Medicaid long-term care policy should address institutional bias and reflect what most seniors and persons with disabilities say they want and need, which is to stay at home in their communities in the least restrictive or most integrated setting appropriate to their long-term care needs in a place they call home.**

- New Medicaid policy should respect beneficiary preferences.
- States should explore and build on new long-term care options authorized by the Deficit Reduction Act of 2005. States, the Centers for Medicare and Medicaid Services (CMS), and Congress should be encouraged to utilize existing Medicaid resources to maintain and/or incorporate long-term care services within Medicaid State Plans that include nursing facilities, personal care, respite care, Intermediate Care Facilities for the Mentally Retarded (ICF/MR), home health, adult day services and other services currently offered in state plans and as Home- and Community-Based Services (HCBS). In most cases, home- and community-based services are less expensive than institutional services and preferable to the beneficiary.
- States should expand use of the Cash and Counseling model.

**B. Benefit Design**

Since its inception, Medicaid has operated as a state-designed program within broad federal guidelines. This flexibility has been critical for states to respond to the health insurance markets and population needs in their states. The Commission believes that further flexibility is necessary to foster continued innovation and improved program efficiency.

**1. States should be given greater flexibility to design Medicaid benefit packages to meet the needs of covered populations. This flexibility should include the authority to establish separate eligibility criteria for acute and preventive medical care services and for long-term care services and supports and the flexibility with benefit design to allow states the**

option to offer premium assistance to allow buy-in to job-based coverage or to purchase other private insurance.

2. Federal Medicaid policy should promote partnerships between states and beneficiaries that emphasize beneficiary rights and responsibilities and reward beneficiaries who make prudent purchasing, resource-utilization, and lifestyle decisions.
3. States should have the flexibility to replicate demonstrations that have operated successfully for at least two years in other states, using an abbreviated waiver application process. Waiver applications to replicate such demonstration programs should be automatically approved 90 days after the date of application unless the application does not meet the replication criteria.
4. Compliance with existing regulations regarding the public notice and comment period about state proposals that would significantly restructure Medicaid (1115 waivers and state plan amendments) should be monitored and enforced.

### **C. Eligibility**

The categorical nature of Medicaid eligibility has created a complex patchwork of coverage for targeted groups of individuals. Much money and effort are expended on the mere administration of Medicaid eligibility, which could be simplified. In addition, the Commission believes there are viable options for covering the uninsured other than public program expansion and encourages the United States Department of Health and Human Services (HHS) and Congress to consider other federal financing approaches to address this issue.

1. Medicaid eligibility should be simplified by permitting states to consolidate and/or redefine eligibility categories without a waiver, provided it is cost-neutral to the federal government.
2. The federal government should provide new options for the uninsured to obtain private health insurance through refundable tax credits or other targeted subsidies so they do not default into Medicaid.
3. Medicaid's core purpose is to serve needy low-income individuals, especially the most vulnerable populations. Therefore, the Commission recommends a study of a new "scaled match" funding formula in which the federal government would reimburse states at an enhanced matching rate for adding lower-income populations to the program, with the match rate scaling back as they expand Medicaid to higher-income populations. Fiscal implications, including cost neutrality, should be considered.

### **D. Health Information Technology**

As the largest purchaser of health care services in the nation, HHS is well-positioned to lead the health information technology adoption effort and should continue to aggressively pursue policy and financing initiatives that will promote the implementation of interoperable health information technology, especially among state Medicaid programs and Medicaid health care providers.

1. The Commission wants to emphasize the importance of investments in health information technology. The Commission, therefore, recommends that the budget scoring process utilized by the Congress amortize the cost of investments in health information technology over a period of five years, while also accounting for the long-term savings.
2. HHS should continue to aggressively promote and support the implementation of health information technology through policy and financing initiatives while ensuring interoperability.
3. All Medicaid beneficiaries should have an electronic health record by 2012.
4. State Medicaid agencies should include in contracts or agreements with health care providers, health plans, or health insurance issuers that as each provider, plan, or issuer implements, acquires, or upgrades health information technology systems, it shall adopt, where available, health information technology systems and products that meet recognized interoperability standards.
5. HHS, state Medicaid agencies, and their vendors shall assure that health information technologies that are acquired or upgraded continuously meet federal and state accessibility requirements.

#### **E. Quality and Care Coordination**

The Commission believes that quality must be brought to the forefront of any discussion about reforming the Medicaid program. Our most vulnerable Medicaid beneficiaries need better care coordination and all Medicaid beneficiaries need a medical home.

1. States should place all categories of Medicaid beneficiaries in a coordinated system of care premised on a medical home for each beneficiary, without needing to seek a waiver or any other form of federal approval.
2. The Commission recommends the following reform proposals to support the development and expansion of integrated care programs that would promote the development of a medical home and care coordination, while also providing necessary safeguards, for dual eligible beneficiaries:
  - **State Plan Option.** Allow states to integrate acute and long-term care benefits/services for dual eligibles through Special Needs Plans (SNPs) or other mechanisms via the state plan.
  - **Inclusive Participation.** Allow states to operate an integrated care management program that provides for “universal” (automatic) enrollment of dual eligibles with an opt-out provision, thus preserving beneficiary choice while allowing states to have a mechanism to improve the care and cost-effectiveness of care provided.
  - **Streamline Medicaid and Medicare Rules/Regulations.** Identify opportunities to reduce administrative barriers to an integrated approach to care (e.g., marketing, enrollment, performance monitoring, quality reporting, rate setting/bidding, and grievances and appeals).



- **Dual Eligible Program.** Authorize states to implement, at their option, a new program for dual eligible beneficiaries, called *Medicaid Advantage*, that integrates Medicare and Medicaid benefits (e.g., primary, acute, behavioral, long-term care services and supports). *Medicaid Advantage* programs, modeled after the Medicare Advantage program, yet managed by the states, would provide a medical home and better coordinated care for dual eligible beneficiaries. *Medicaid Advantage* programs would also provide both the federal and state governments more predictability in budgeting for the significant portion of their Medicare and Medicaid spending on dual eligibles. The federal government would continue to provide financial support for Medicare services through a risk-adjusted, capitated system of Medicare payments. States and the federal government would continue to share the cost of the Medicaid portion of the benefit. Medicare Part D drug coverage would be integrated into the *Medicaid Advantage* plans. States or the plans they select could manage the full spectrum of services to provide an integrated care delivery program for dual eligible populations under streamlined rules and regulations. These plans would collect and evaluate treatment data, and states and the federal government would monitor the plans to make sure obligations are being met. Plans would be required to provide core Medicaid and Medicare services, and patients would have the ability to opt-out. States would have the ability to create new incentives for quality.
- **Savings.** States and the federal government should share in savings for dual eligible members that are achieved through innovative care management strategies resulting in improved clinical and financial outcomes.

**3. CMS should establish a National Health Care Innovations Program to 1) support the implementation of state-led, system-wide demonstrations in health care reform and 2) make data design specifications available to all other states for possible adoption.**

**4. State Medicaid agencies shall make available to beneficiaries the payments they make to contracted providers for common inpatient, outpatient and physician services.**

**5. In order to pay for quality, states must first be able to measure it. Therefore, states should collect and mine data on how Medicaid money is being spent to determine which programs, providers, and services are effective and which need improvement.** Payments to Medicaid providers then should be tied to objective measures of risk- and case-adjusted medical outcomes. This will lead Medicaid to become more patient focused, i.e., funding health care in a way that assures patients are getting the care they need.

**6. CMS and Congress should support state innovation to deliver value for taxpayer dollars by purchasing quality health care outcomes as opposed to simply reimbursing for health care processes.** The Commission, therefore, recommends that CMS and Congress provide enhanced match and/or demonstration funding, to be recouped from savings over a five-year period, to support upfront investments in quality improvement in targeted areas: development/enhancement of standardized performance measures, particularly for children, persons with disabilities, populations who experience disproportionate health disparities, and the frail elderly; implementation of care management programs targeted at high-risk, high-cost, co-morbid beneficiaries; and the creation of provider-level pay-for-performance programs.

### Remaining Challenges

While this Commission has accomplished much over the past 18 months, a number of issues have been identified that were deemed to be beyond the scope of our charter, but which cannot be ignored by policymakers who are considering Medicaid reform. The current open-ended federal-state financing arrangement and the procedure for determining the amount of federal dollars that flow to states using the formula for the Federal Medical Assistance Percentage (FMAP) should be examined in a comprehensive manner for possible reform. The more-limited study recommendation found in C.3 above may serve only as a precursor to more in depth analysis. Additionally, policymakers should examine whether the projected workforce supply is adequate to support our nation's health care delivery system, especially one with an increased focus on home- and community-based services. Finally, the Commission acknowledges that access to affordable housing creates barriers to providing cost-effective home- and community-based health care for Medicaid beneficiaries.

The Commission was given the task of addressing the long-term sustainability of the Medicaid program. Taken together, our recommendations lay a solid foundation for fiscal sustainability, while also improving the efficiency and quality of care for Medicaid beneficiaries. Yet we recognize that Medicaid is only one part of a larger health care system and there are forces affecting that system that Medicaid, alone, cannot impact. We have laid the groundwork and HHS and stakeholders must continue the necessary work on our nation's overall health care challenges to chart a fiscally responsible path for providing health care to our nation.

**Medicaid Commission**  
*Roster of Commissioners*

Voting Members

The Honorable Don Sundquist  
Chair  
Former Governor of Tennessee  
Founding Partner, Sundquist Anthony LLC  
Townsend, TN

The Honorable Angus S. King, Jr.  
Vice Chair  
Former Governor of Maine  
Partner, Bernstein, Shur, Sawyer & Nelson  
Brunswick, ME

Nancy V. Atkins, M.S.N, R.N.C, N.P.  
Commissioner  
Bureau for Medical Services  
West Virginia Department of Health and  
Human Resources  
Charleston, WV

Melanie Bella, M.B.A.  
Vice President for Policy  
Center for Health Care Strategies, Inc.  
Princeton, NJ

The Honorable Jeb Bush  
Governor of Florida  
Tallahassee, FL

Gail C. Christopher, D.N.  
Vice President  
Office of Health, Women and Families  
Joint Center for Political and Economic  
Studies  
Washington, DC

Gwen Gillenwater  
Senior Director for Policy and Outreach  
American Association of People with  
Disabilities  
Washington, DC

Robert B. Helms, Ph.D.  
Resident Scholar in Health Policy Studies  
American Enterprise Institute  
Washington, DC

Kay Coles James  
President  
The Gloucester Institute  
Fairfax Station, VA

Troy Justesen, Ph.D.  
Assistant Secretary of Vocational and Adult  
Education  
Department of Education  
Washington, DC

The Honorable Joseph Manchin  
Governor of West Virginia  
Charleston, WV

S. Anthony McCann  
Secretary  
Maryland Department of Health and Mental  
Hygiene  
Baltimore, MD

Jerry Regier  
Principal Deputy Assistant Secretary for  
Planning and Evaluation  
Department of Health and Human Services  
Washington, DC

William N. Shiebler  
Non Executive Vice Chairman of Deutsche  
Asset Management  
Deutsche Bank  
Park City, UT

Grace-Marie Turner  
President, Galen Institute  
Alexandria, VA

### Non-Voting Members

James M. Anderson  
Chairman and CEO  
Cincinnati Children's Hospital & Medical Ctr.  
Cincinnati, OH

Julianne O'Connell Beckett  
National Policy Coordinator  
Family Voices  
Cedar Rapids, IA

Carol Berkowitz, M.D., F.A.A.P.  
Past President  
American Academy of Pediatrics  
Executive Vice Chair and Professor  
Department of Pediatrics  
Harbor/UCLA Medical Center  
David Geffen School of Medicine at UCLA  
Los Angeles, CA

Maggie Brooks  
County Executive  
County of Monroe  
Rochester, NY

Mark de Bruin  
Senior Vice President of Pharmacy Services  
Rite Aid Corporation  
Camp Hill, PA

Valerie J. Davidson  
Senior Director of Legal & Intergovernmental  
Affairs  
Alaska Native Tribal Health Consortium  
Anchorage, AK

John D. Kemp  
Principal  
Powers, Pyles, Sutter & Verville, PC  
Washington, DC

Joseph W. "Chip" Marshall III  
Chairman and CEO  
Temple University Health System  
Philadelphia, PA

John P. Monahan  
President, State Sponsored Business  
Wellpoint  
Camarillo, CA

John C. Nelson, M.D.  
Immediate Past President  
American Medical Association  
Salt Lake City, UT

Joseph J. Piccione  
Corporate Ethicist and Corporate Director  
Mission Integration  
OSF Healthcare System  
Peoria, IL

John Rugge, M.D.  
Chief Executive Officer  
Hudson Headwaters Health Network  
Glens Falls, NY

Douglas A. Struyk  
President and CEO  
Christian Health Care Center  
Wyckoff, NJ

Howard Weitz, M.D., F.A.C.P., F.A.C.C.  
Professor of Medicine  
Co-Director, Jefferson Heart Institute  
Senior Vice Chair for Academic Affairs  
Jefferson Medical College  
Thomas Jefferson University  
Jefferson Heart Institute  
Philadelphia, PA

Joy Johnson Wilson  
Federal Affairs Counsel & Health Policy  
Director  
National Conference of State Legislatures  
Washington, DC